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Clinical hypnosis and the anaesthetist: a practical approach

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Learning objectives

By reading this article you should be able to:

- Discuss that the use of clinical hypnosis is evidence-based, effective and has a sound neurobiological basis.
- Integrate hypnotic techniques into your clinical practice to improve care.
- Explain more complex ideas of clinical hypnosis.
- Know that formal hypnosis training can enhance clinical practice, teaching and research.

Key points

- Hypnosis is a focused conscious experience that can be used to deliver a hypnotic intervention.
- Key features of hypnosis are dissociation between conscious and subconscious processes, associated with non-volitional patient responses.
- Building trust and rapport by listening to the patient and accepting their reality optimises the chance of a therapeutic response to a hypnotic intervention.
- Patients are frequently in spontaneous hypnosis when in the acute care environment.
- Every communication has the potential to function as a suggestion leading to therapeutic or nocebo effects. Negative suggestions (nocebo) should be avoided wherever possible.

Clinical hypnosis is increasingly being recognised as an evidence-based, non-pharmacological therapy with a sound neurobiological basis.[1–5] It is inexpensive, safe, effective and requires no special equipment.[6–9] It can potentially be used with different groups of patients and in a range of clinical settings.[10–15] Its therapeutic benefits, in the context of anaesthesia, can usually be realised in minutes or even seconds.[16] Patients in the stressful perioperative environment have an increased likelihood of experiencing spontaneous hypnotic states and therefore are particularly responsive to the therapeutic effects of a hypnotic intervention, especially in providing anxiolysis and analgesia.[7,17,18]

Spontaneous hypnotic experiences are universal in everyday life. They are typically recognised as periods of focused internal attention on a particular activity or thought process.[18] For example, becoming so internally absorbed in a book or conversation that the internal world effectively replaces the usual conscious awareness of the external environment. Similarly, functioning on 'autopilot', yet driving safely on a familiar route, occurs without conscious

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awareness of complex decisions. In sports, the phenomenon of hypnotic anaesthesia (Table 1) can occur when the pain of an injury may not reach conscious awareness until the game has finished. This conscious–subconscious construct can be recognised in our everyday descriptions of the experience: *'being in two minds about something' or 'besides oneself'; 'tuning out'; 'daydreaming'; and 'out-of-body experiences'*.

Traditionally, hypnosis is defined as '**a state of consciousness involving focused attention and reduced peripheral awareness characterised by an enhanced capacity for response to suggestion**.'[17] Hypnotic states and phenomena can arise spontaneously or be induced by a therapist or the patient (self-hypnosis).[7] Clinical hypnosis in anaesthesia involves the use of a patient's spontaneous hypnotic state, or (less commonly) the purposeful induction of hypnosis, to modify a patient's experience in a therapeutic way Fig. 1.

Neurobiological correlates of hypnosis

The rapid expansion and sophistication of neuroimaging techniques since the late 1990s has identified specific changes in brain function during hypnosis and in response to suggestion.[19–23] In particular, pain perception under hypnotic conditions involves cortical and subcortical areas, primarily the anterior cingulate.[3,5,24] Neuroimaging also shows that hypnotic depth and hypnotisability are not synonymous and that hypnosis correlates with activation of the lingual gyrus, where higher order visual processing and mental imagery are processed.[25] Enhanced hypnotic suggestibility has been associated with lower EEG signal variability, particularly in the theta frequency band.[3,24] The neurobiology behind the altered sense of agency experienced during hypnosis and the non-volitional nature of responses to suggestion, are examined in detail elsewhere.[4,5,24–26]

Hypnosis and anaesthesia in context

John Elliotson, the first professor of medicine at London University, paved the way for modern anaesthesia by showing that the long-held dream of pain-free surgery was feasible using hypnosis.[27] The French surgeon Cloquet recorded the first use of perioperative hypnosis when he amputated a breast painlessly in 1829. The Scottish surgeon, James Esdaile (a protégé of Elliotson) reported successfully using hypnosis in India in 1846 for several thousand operations.[28] That same year pharmacological anaesthesia was born, effectively ousting hypnosis at the height of its popularity. More than 150 yrs ago, James Braid, surgeon and pioneer of modern-day clinical hypnosis, recognised hypnosis could be used to enhance care in conjunction with medical treatment.[27] Indeed, clinical hypnosis has shown substantial benefits when used as an adjunct to anaesthesia care.[2,29,30] Despite well documented case reports of hypnosis being successfully used as a sole anaesthesia technique, it is surprising that hypnosis has not been considered a topic worthy of clinical application or scientific study until relatively recently.[31–33] Indeed, it was not until 2023 that the first randomised clinical trial comparing hypnosis with general anaesthesia was conducted.[34]

Hypnotic concepts relevant to the anaesthetist

Hypnotic states represent a fluctuating, highly variable continuum of conscious awareness. At one end there is full

Table 1 Hypnotic phenomena relevant to the anaesthetist.

Phenomena	Description	Example
Anaesthesia/analgesia	Changes in sensory perception to develop anaesthesia of a body part to a variable degree.	Arm anaesthesia to aid cannulation (e.g. '*Imagine as you put on that glove soaked in local anaesthetic … as it bathes the skin, soft tissues, ligaments and muscles … **feel the comfort** spreading more and more*').
Catalepsy	Inhibition of voluntary movement, fixing the position of part of the body.	'*As the hand becomes more and more heavy and relaxed, you will find it can **stay still like a statue**'.*
Time distortion	Altered perception of the passage of time.	During a stressful procedure (e.g. '*Many patients are surprised when they look back … it seems like it all went by in a flash*').
Age regression	Focus on past helpful experiences to facilitate success in the present.	A patient feeling anxious (e.g. '*I wonder when a past experience will come to mind where you felt comfortable and in control or surprised by your achievement*').
Age progression	Focus on a future positive outcome.	Before anaesthesia (e.g. '*You can look forward to eating and drinking after the procedure and getting ready to go home*').
Dissociation	Separation of awareness of different parts of the body and mind.	During an anaesthetic procedure (e.g. '*as one part of your mind rests on a beach, another part of your mind allows the arm to feel numb …* ').
Arm levitation	Non-volitional arm raising to suggestion.	During burns dressings (e.g. '*Every time you breathe in the arm will feel lighter … until it just wants to drift up all on its own … and each time you breathe out, feel yourself relax … The more relaxed you feel the lighter the arm … the lighter the arm, the more relaxed you can feel …* ').

Table 2 Frequently asked questions.

Question	Answer
What is the difference between formal and informal hypnosis?	Formal hypnosis usually requires training, involves a structured series of steps and is usually reserved for patients preparing for surgery or in the outpatient setting managing chronic pain or severe needle phobia. In anaesthesia, informal/conversational hypnosis is more commonly used.
If the patient asks: '*is this going to sting?*' Aren't I lying if I don't warn the patient that it does?	It is essential to be honest in our response. Not all patients will experience a sting so if we say, ***it will sting***, this response will be untruthful in some cases. Possible responses include: *You may or may not notice something; I don't know, most people are surprised it's more* comfortable *than they thought*.
Isn't hypnosis too time consuming?	Hypnosis usually saves time as it often allows procedures to proceed that would otherwise be prolonged or even abandoned.
Can you be hypnotised against your will?	In the context of ethical clinical anaesthesia practice this is extremely unlikely. Patients can usually terminate the experience in the same way they would if absorbed in reading a book and the phone rang. However, in a vulnerable subject, hypnosis without consent is possible.
What is the difference between stage hypnosis and medical hypnosis?	The main difference is context—subjects on stage appear to be under the control of the hypnotist. However, they have participated in a series of brief psychological tests beforehand designed to identify their hypnotic capacity and motivation to respond positively in the context of entertainment. Medical hypnosis represents a therapeutic relationship co-created between clinician and patient.
Should anaesthetists get consent for hypnosis before using it?	For conversational hypnosis, consent is unnecessary. Anaesthetists already use suggestion without appreciating their language is hypnotic. Some anaesthetists communicate negative suggestions with the potential for nocebo effects yet do not ask patients for their consent to use potentially harmful language. An informed consent discussion is appropriate if patients are being formally induced or taught 'self-hypnosis'.
Is hypnosis contraindicated in some patients?	There are no absolute contraindications. It is advisable to only use formal hypnosis with patients you would treat without hypnosis. For example, only psychiatrists should use hypnosis to manage patients with bipolar disorder or schizophrenia. The conversational hypnotic techniques described in this article are safe to use with all patients.
Do I need to be trained before using these techniques?	As with any anaesthetic technique, training is always preferred to achieve optimal results. There is no legal obligation in many jurisdictions such as the UK and Australia, where hypnotherapy is deregulated.
Do I need to document the hypnosis technique(s) used?	Yes. As with any other anaesthetic procedure (epidural, arterial line) if formal hypnosis is used or if specific hypnosis techniques are utilised during conversational hypnosis (e.g. lived in imagination, switch wire imagery), these should be documented.
Is hypnosis dangerous? Are there side-effects?	Very occasionally, patients may have a strong emotional reaction (abreaction) to something suggested. This is managed supportively using reassurance and keeping the patient in hypnosis until the emotion dissipates. Tears during hypnosis does not usually indicate distress. Patients can be asked to describe what they are experiencing as they are able to speak, especially if this is suggested.

consciousness of external surroundings, whilst at the other, an internal focus and absorption so intense that the patient dissociates from the external world. An example being hypnotic anaesthesia (Fig. 1 online video).[35] In hypnosis, language processing is altered and words are interpreted without the usual cognitive filtering. '*As you notice the colour of the pain changing, you may start noticing other transformations*.'

Supplementary video material related to this article can be found at https://doi.org/10.1016/j.bjae.2024.01.005

Trance logic is a feature of the hypnotic state where a concept or idea is accepted as logical that would normally be considered illogical outside the hypnotic experience. For example, suggesting that a labour contraction can allow the mother to feel stronger. '*Knowing each contraction, as it gets stronger, is becoming more effective in getting you closer to seeing your baby, the stronger the contraction, the stronger you can feel*.'

Dissociation is a key feature of hypnosis explicitly recognising conscious and subconscious separation to facilitate a hypnotherapeutic outcome. '*Whilst one part of your mind* (conscious) *is walking in a rainforest, another part* (subconscious) *can allow the arm to become tingly, heavy and numb*.' The concept of dissociation explains why patients often perceive changes

Fig 1 Dr GR Wicks, Clinical hypnotherapist assisting a patient have surgery using hypnosis as a sole anaesthetic technique for open abdominal surgery.

as involuntary (happening outside of direct conscious control) (e.g. *the arm seemed to lift all by itself*, Table 1).

Hypnotisability is a patient's responsiveness to hypnotic suggestions as changes in physiology, perceptual experiences, emotions or behaviours.[17] Populations with increased hypnotisability include children in their play and make-believe world, and women when pregnant.[11,36,37]

Hypnotic depth is the degree to which a patient's conscious processing of external stimuli is altered by the hypnotic state. This can vary from a daydream type experience to one where full surgical anaesthesia can be achieved (Fig. 1 online video).[3]

Hypnotic phenomena arise from the hypnotic state itself and in response to suggestion (Table 1). They represent physiological correlates of hypnosis and non-volitional hypnotic responses to suggestion.

Hypnotic techniques

Creating positive expectancy, by believing that patients can do more than they think they can and more than the anaesthetist thinks they can, is likely to enhance the therapeutic effects of any interaction between anaesthetist and patient. The patient's role has traditionally been viewed by clinicians as being 'the field of play' on which all the action takes place by members of the healthcare team—surgeons, nursing and anaesthesia staff (e.g. venesection, cannula insertion, nerve blocks). In contrast, clinical hypnosis requires healthcare professionals to include the patient as a full member of the team by recognising the patient's own unique skills and resources. This paradigm shift in approach empowers patients to actively participate in their care.[38] This is primarily achieved by providing patients with choice and a sense of control: '*can you show me your best vein?*'

Language structures

The LAURS acronym (listening; acceptance; utilisation; reframing; suggestion) provides a framework that deconstructs the elements of intuitive communication. It builds patient rapport and provides structure through which specific clinical hypnosis techniques can be embedded within a therapeutic interaction.[39] Hypnosis techniques can empower patients to modify their distress and allow cooperation in ways that facilitate the conduct of a procedure that would otherwise be prolonged or even thwarted (Figs 2 and 3 online videos). This approach has the added advantage of allowing anaesthetists to reach the coffee room in both a timely, and more relaxed, manner!

Specific techniques

Suggestion involves verbal or non-verbal communications targeting subconscious processes that elicit non-volitional changes in perception, mood or behaviour.[40] Patients processing suggestions subconsciously amplify particular aspects of their experience, whether negative, giving rise to nocebo effects, or positive, giving rise to therapeutic effects. For example, giving a sick bowl (non-verbal negative suggestion) when patients are asymptomatic may result in them feeling nauseous or even vomit. In contrast, a therapeutic verbal, direct, positive suggestion might be: '*we are giving you medication to settle the stomach and help you feel like eating and drinking*'. Suggestions with 'You' are direct suggestions, '*You will find …* '

Talking about other people is indirect and implies the patient will experience the same thing. '*Most people find ….*'

Minimising nocebo effects—it is essential that anaesthetists consider minimising the use of negative suggestions likely to

induce nocebo effects.[41] Words such as *Sting*, *Hurt*, *Worry*, *Pain*, *Vomit*, *Nausea*, *Itch*, *Anxious*, are ubiquitous in perioperative care. Communicating in a way that re-enforces or creates negative expectancy should be avoided. Rather than give the negative suggestion, '*sharp scratch coming, sting, sting, sting, just starting to insert the needle now — sorry!*' before an injection of local anaesthetic, consider saying instead, '*just numbing the skin to allow us to finish the procedure more comfortably*'.

Even pain scores, asked of patients not complaining of pain, may suggest a negative focus of injury and disability, rather than symptom resolution, cure, healing and recovery. Repeatedly asking patients for their pain scores after surgery can result in a four-fold increase in requests for analgesia.[42] However, when managing patients in pain, or patients implying that pain is being experienced, anaesthetists should not be reticent about addressing pain directly. This is achieved by reflecting the patient's own description—sore, hurting, excruciating etc. This is an example of accepting the patient's reality—a first essential step towards a shift in their thinking.

Seeding is the generation of positive expectancy and can be achieved in many ways (e.g. theatre staff expressing confidence in the anaesthetist's abilities). *You've got Dr Wonderful today. They are very experienced and such a nice doctor …*

'*Yes sets*' build a therapeutic alliance by posing a series of questions that are designed to elicit a positive response as many times as possible. This allows patients to move from the generic (see truisms below) to the specific. As part of building rapport, you approach Mary-Anne-Jane and ask, '*What would you like to be called?*' The patient replies, *Scotty*. By using Scotty's preferred name, a 'yes set' and patient rapport begins. *So just to clarify, is it OK for me to call you Scotty?* If the response is '*Yes*' this generates the beginning of a 'Yes set'. This builds a momentum that increases the likelihood of subsequent suggestions being accepted.

Truisms can be a part of a 'yes set'. *All patients are different*; *hospitals are full of different experiences*; *anaesthetists are highly trained and skilled in keeping patients safe during surgery*.

Physiological truisms are statements that generate a 'Yes' in the brain coinciding with a physiological response. For example, '*most people find that as the tourniquet tightens, they notice a change in sensation*.' The 'yes' accepted by the patient in association with the physiological truism of sensory change associated with blood flow restriction is the first step towards the patient accepting a series of suggestions that may ultimately result in a profound experience of the hypnotic phenomenon of 'arm anaesthesia'. In the context of pre-oxygenation, the anaesthetist can use the relaxation of the chest wall as the patient breathes out to functional residual capacity. '*As you breathe out you can feel yourself relax*'. The patient subconsciously recognises chest wall relaxation and experiences a 'yes' in the brain). '*Each time you breathe out, you can feel yourself relax even more*' (patient experiences another 'yes').

Pacing—the anaesthetist can then reinforce the suggestions above paced with exhalation, *That's right!* (as the patient exhales), *Well done!* (as the patient exhales), *That's good!* (as the patient exhales), *Excellent!* After five or six breaths, patients frequently experience the suggested relaxation response to the rest of the body.

Time distortion is a hypnotic phenomenon (Table 1) that can be readily utilised in anaesthesia. For example, in the MRI scanner (suggesting time can pass in a flash) or in the context of a labour epidural, it can be suggested; '*As you focus on the rest that follows each contraction, the rest can start seeming much longer and the contractions much shorter than they really are. You can be surprised how quickly you recover from the surgery*.'

Double binds provide patients with a choice of comparable alternatives leading to the same outcome. This technique is an effective way of giving patients a sense of control. For example, during an inhalation induction the patient can be asked, '*Would you prefer to breathe in the gas or blow it away?*' Either choice involves an inhalation. Similarly, the question, '*Would you like to climb on the bed all by yourself or would you like mummy to help you?*' allows a child to actively participate in their care and enhance cooperation even though the only choice is lying on the operating table rather than on mum's lap!

Preventing sabotage—interruptions and negative suggestions from nursing staff, surgical colleagues and well-meaning parents can be problematic. Ongoing education to staff about nocebo effects and how to avoid negative suggestions can be helpful. On the day of surgery additional strategies for accompanying parents may be required. '*We find that when going into the operating room, children are more likely to relax and cooperate when only one person does the talking. Is it OK if that person is me?*'

Starting vs finishing—this concept avoids anticipatory anxiety before a procedure and focuses the patient on its successful completion. For example, before placing an i.v. cannula, the anaesthetist can state '*We're just about to finish!*' rather than '*We're just about to start*.'

Reframing comments such as '*Sorry we are going to have to stick a cannula in to stop you feeling sick*' can be reframed by the therapeutic intent: '*We are placing the drip to rehydrate you and give you medication to allow the tummy to settle and help you feel like eating and drinking a little sooner after surgery*.'

Asking the patient's permission at each stage of a procedure is a quick and easy way to build rapport, continues the 'yes' set, confirms ongoing consent and provides the patient with an element of control culminating in the successful completion of a procedure (Figs 1 and 3 online videos). *Putting it all together*—"*Is it OK to look at the arm? Is it OK to position the tourniquet to facilitate drip placement? As the tourniquet tightens you may or may not notice the arm change sensation. Is it OK to wipe some of the sensations away with antiseptic so the arm can feel even sleepier and more relaxed than it is already? Is it OK to finish up?*' Some patients may have difficulty verbalising consent to proceed. '*If you find it difficult to speak, just nod your head when you are ready for me to finish*.' This allows extremely anxious patients who cannot verbalise, to nod subconsciously to allow completion of the procedure (Supplementary material S4).

What if the patient says no?—should the patient say '*No, I can't do this!*' at any stage, it is essential to stop temporarily to show the patient they are in control. They can then be asked, '*Let me know when you are ready for us to finish up?*' If a patient asks directly, '*Will this be painful?*', honesty is essential. Possible responses could include: '*some patients tell me it is, whilst others say it was more comfortable than they thought*' (indirect suggestion). Or, '*I don't know, everybody experiences things in a different way*' (indirect suggestion). Or, '*You will feel what you feel!*' (direct suggestion). This statement not only avoids nocebo communication but is confusional and therefore likely to deepen the hypnotic experience.

Techniques and concepts for the more adventurous anaesthetist

LAURS for the challenging patient who says no

Patient: '*No, I can't do this! I* ***can't listen to you! I can't listen to you! I can't listen*** *to you! It's all too awful*'.

Listening for the patient's words and letting the patient know they have been heard, understood and believed, is the first step in building trust and rapport. This leads to empowering patients to feel they have some control over what is happening.

Acceptance: '*I know you can't listen at the moment*' *and …*

Utilisation: '*even though you can't listen to me* (embedded direct suggestion), *that's OK* (acceptance).

Reframing: **'***In a moment, but not yet,* (creating positive expectancy, seeding) *you will hear everything you need..*' (direct suggestion).

Suggestion: ''*to allow us to finish up safely and comfortably*.'' (direct suggestion).

This approach builds trust and rapport, facilitates patient cooperation, creates positive expectancy towards the therapeutic outcome and tends to avoid nocebo effects. It is particularly effective when interacting with anxious patients.

Post-hypnotic suggestion is communicated in hypnosis to come into effect at some future time. Successes can be reinforced and utilised. '*Now you have had this amazing achievement today, you know you can do this. Should you need anything like this in the future, it can be approached with confidence and a sense of control. Knowing that when we practice something it gets easier, people become more confident in their abilities and that with each success, at some point it just seems to happen all on its own without you even thinking about it*'.

Looking out for perceptual language to build rapport

Many patients use perceptual (kinaesthetic, visual or auditory) words as part of their interaction with the anaesthetist which can be used to build rapport. Patients might say something like '*I feel weighed down by everything that's been going on* (kinaesthetic), *I'm not looking forward to the anaesthetic*' (visual). Or '*I hear what you say but it doesn't sound very clear where this is all going*' (auditory). Possible responses might include: '*Perhaps you can take off a backpack of the unhelpful things that have been weighing you down before we start the anaesthetic, so you can let go of unhelpful thoughts and feel a little lighter or even weightless as you recover from the surgery*' (kinaesthetic); '*You may not be looking forward to the anaesthetic but perhaps you can see yourself recovering with a settled stomach ready to eat and drink something you really like a bit sooner than you might think*' (visual); '*I'm just going to explain what's happening in a different way so that it can sound a bit a clearer*' (auditory).

Two types of knowing

'*You know you can do this!*' implies that the patient deep down (i.e. subconsciously) knows he/she can complete the procedure. The unsaid phrase is '*You just don't know* (conscious) *that you know*' (subconscious) '*you can do this yet!*'. Patients invariably know subconsciously that they can finish the procedure—if this was not so they would not have gone along with it in the first place. If the patient appears to be having difficulty, the anaesthetist could say '*I believe in you; you know you can do this!*' (we recognise this may be a bridge too far for some).

Failure words: try, sorry and not

'*Try*' is a failure word that needs to be used with caution as it inherently suggests failure (e.g. '*We will try and fit you in before midday*').

> '*Not*' is ignored by the subconscious. '*Try not to move*' becomes a suggestion to '*move*'.

Saying sorry before a procedure is unhelpful as it creates a negative expectancy and raises the question why the anaesthetist is apologising for helping the patient. Apologising after a procedure is another matter. If the patient finds the procedure prolonged, difficult, or painful it is certainly appropriate to apologise—'*I am sorry that was so prolonged/difficult/uncomfortable for you*.' The word, '*sorry*' can also be used to overcome conscious and subconscious resistance for therapeutic effect. For example, during a hypnotic approach to arm anaesthesia before cannula placement, the anaesthetist can apologise for the arm becoming *too numb and sleepy*.

Sometimes patients will say something that can be utilised such as, *I can't relax!* The anaesthetist can respond, *That's OK* (acceptance), *Why don't you try not to relax then!* The confusion generated takes the patient deeper into hypnosis which then makes the suggestion to relax more likely to be realised as a non-volitional behavioural response.

Metaphor and story

Metaphors frequently convey meaningful information that can be utilised by the anaesthetist—particularly in patients suffering chronic pain or needle phobia. Metaphors embedding negative suggestions, such as '*We are attacking you from all sides, Sorry, if I'm strangling you with the ECG leads, I've made you into a pincushion, We are putting him to sleep now!* (euthanising a pet), *We are going to put you under* (drowning), *Would you like to kiss your child goodbye?*' (death), should be avoided. When patients (or anaesthetists) express that they have *tried everything*, rather than give yet another painkiller, there is an opportunity for the anaesthetist to provide a metaphor, *Have you turned down the pain dial in your mind?* This question may facilitate confusion that deepens the hypnotic experience allowing for surprising responses that can be utilised and reframed.

The following metaphor may help anaesthetists understand how they work. '*If I was to ask my blood vessels to dilate, they wouldn't do it, as this is a conscious command that the autonomic nervous system can't understand or respond to. And yet, if I imagine myself in an embarrassing situation*' (such as, worrying about being perceived as crazy writing this section to sceptical anaesthetists), '*the blood vessels of my face might dilate leading to a blush.*' The underlying message is that no matter how impossible a situation seems, a therapeutic solution can always be found.

Imagery and imagination techniques

Safe place—'*Going to a safe place in your mind is an easy way to relax and become comfortable. It is different for everybody. Sometimes it's a comfy chair at home watching TV, or reading a book, or walking on a beach, whatever the most comfortable place is for you …. Just find yourself noticing the sights, the sounds, the tastes, the smells, and just enjoy the peace, the calm, the comfort.*'

Basket of cares and worries (BOCAW)—**'***We all in our daily lives carry around excess baggage, stuff we don't need that stops us doing*

things we want to do and want to achieve. In your safe place you can find a container or basket – in which you can place and offload some excess baggage, unnecessary thoughts or worries, anything unhelpful to your recovery can be placed in the basket. When you have put as much of the unhelpful stuff as you can for just now, tie some helium balloons to the basket and let it float off until it is a pinpoint dot on the horizon.'

Formal hypnosis for anaesthetists

The steps of formal hypnosis have parallels with conventional anaesthesia. The interaction consists of: an induction; deepening; maintaining hypnosis with therapeutic suggestions; and an alerting procedure (Table 2).

Rapid hypnosis induction: '*In a moment, but not yet* (creates a positive expectancy) *when you are ready to go to your safe and comfortable place in your mind, allow the eyes to close*' (suggestion—note the eyes will only close when the patient is ready to go to their safe place). '*Notice the sights, the sounds, the tastes, the smells, the temperature, the humidity*'.

Lived-in imagination (aka 'believed-in imagination') is a hypnosis technique that allows the clinician and patient together to create a hypnotic reality that feels real.[18] It has multiple applications, for example, cannula insertion, to supplement a less than perfect block, or even to provide anaesthesia for surgery as a sole anaesthetic technique in selected patients. It can be used by many anaesthetists with minimal training and involves using imagery the patient has chosen (e.g. eating cheesecake) and asking questions of the patient as if the experience is real. The beginning of a 'lived-in imagination' technique is outlined below (Fig. 2 online video). '*What's happening at the moment? Have you taken the cheesecake out of the fridge? Are you using a fork or a spoon? Is it a small fork? Can you let me know when you have taken your first bite?*'

The hypnotic techniques described represent a small subset of possible uses in anaesthesia care (Supplementary material S4). Appropriately combining multiple techniques enhances the hypnotic effect. Some words presented here may not be suitable for all anaesthetists and contexts. Anaesthetists should avoid saying anything they are uncomfortable with or believe to be untrue (Table 3). Supplementary material S5 provides further resources for those interested.

Table 3 How to start using hypnosis.

Step	Task
1	Identify and avoid negative suggestions you may be using with patients.
2	Replace these with neutral or positive suggestions.
3	Rapport building by active listening—ensure patients feel believed and check-in that you have heard and understood what they are saying.
4	Build 'Yes sets' with patients by asking permission before an action such as examining the back or injecting local anaesthetic.
5	Practice using truisms and physiological truisms when pre-oxygenating or performing a procedure.

Conclusions

It is timely that anaesthetists are re-evaluating the unique advantages of hypnosis in potentially avoiding or limiting the risks of invasive interventions or adverse effects from drugs.[43] Indeed, if hypnosis were a drug, it would have been standard practice decades ago.[9] The use of hypnosis in anaesthetic practice appears too valuable a tool to be left outside the anaesthetist's armamentarium any longer.

Declaration of interests

None declared.

MCQs

The associated MCQs (to support CME/CPD activity) will be accessible at www.bjaed.org/cme/home by subscribers to *BJA Education*.

Supplementary material

Supplementary data to this article can be found online at https://doi.org/10.1016/j.bjae.2024.01.005.

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